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PUBLIC HEALTH SERVICE ACT INFANT MORTALITY AMENDMENTS OF 1987

AUGUST 3 (legislative day, JUNE 23), 1987.—Ordered to be printed

Mr. KENNEDY, from the Committee on Labor and Human Resources, submitted the following

REPORT

[To accompany S. 1441]

The Committee on Labor and Human Resources, to which was referred the bill (S. 1441) to reduce the incidence of infant mortality, having considered the same, reports favorably thereon with an amendment and recommends that the bill as amended do pass.

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I. SUMMARY OF THE BILL

MIGRANT HEALTH CENTERS

The bill expands the fiscal year 1988 authorization for Migrant Health Centers by $3 million. This additional authorization is intended to increase the resources under this program to enable it to combat high rates of infant mortality through expanded and enriched maternal health and child health services.

S543-15

COMMUNITY HEALTH CENTERS

S. 1441 expands the fiscal year 1988 authorizations for the Community Health Centers program by $35 million. This additional authorization is intended to increase the resources under this program to enable it to combat high rates of infant mortality through expanded and enriched maternal health and child health services. The bill also requires the Secretary to give consideration to the needs of rural areas designated as frontier areas. The bill requires that fiscal year 1988 appropriations which exceed $418 million for the Community Health Centers program shall be utilized for grants to support special prenatal services and special perinatal coordinated projects.

AREA HEALTH EDUCATION CENTERS

The bill increases the fiscal year 1988 authorization for the Area Health Education Centers program by $3 million and requires that, of fiscal year 1988 appropriations, $3 million shall be utilized for contracts to support programs that will train personnel to offer maternal and child health services in underserved areas. The bill requires the Secretary to give priority to programs which will train personnel for areas along the U.S.-Mexico border, frontier areas, the Pacific Basin region, and for areas with disproportionately high infant mortality and low birthweight infant rates.

NURSE PRACTITIONERS AND NURSE MIDWIVES

The bill establishes a new program, authorized at $4 million for fiscal year 1988, to provide grants to public and private nonprofit schools of nursing to operate fellowship programs for the training of nurse midwives and pediatric, family, obstetric and gynecologic nurse practitioners. Such programs must give priority to applicants who are employed by Community or Migrant Health Centers, or by Indian Health Service Facilities or Native Hawaiian health centers.

II. Background and Need for Legislation

The United States ranks 17th in the world in infant mortality rate, behind Singapore and Hong Kong. Nearly 40,000 of the 3.7 million children who were born in th United States in 1984 died before their first birthday, a rate of 10.8 infant deaths per 1,000 live births. The disparity between black and white infant mortality is particularly alarming; black infants are nearly twice as likely as white infants to die in the first year of life. At our current rate of progress, the United States has little chance of meeting the Surgeon General's goal of reducing the infant mortality rate to 9 per 1,000 live births by 1990.

Two-thirds of all infant mortality can be attributed to those infants born at low birthweight. In 1987, a quarter of a million low birthweight babies will be born. These infants are 40 times more likely than normal birthweight babies to die in the first month of life, and 20 times more likely in the first year. They are also far more likely to have birth defects and mental and physical handi-

caps, which often mean lifelong challenges, hardships, and expenses for themselves, their families and society.

Low birthweight is largely preventable—and at relatively low cost. Early prenatal care can reduce the number of infants born at low birthweight by two-thirds. The Institute of Medicine has estimated that for every dollar spent for prenatal care, $3.38 would be saved in the total cost of caring for low birthweight infants.

Although lowering risk factors through access to prenatal care is the most effective way to prevent low birthweight, millions of women receive little or no prenatal care. National health statistics compiled by the federal government indicate that, in 1983, nearly one quarter of all pregnant women in the United States did not begin prenatal care in the first trimester of pregnancy. Among teenagers and black women, nearly one-half do not receive prenatal care in the first trimester and poor women were twice as likely to receive no or late prenatal care.

The report of the Institute of Medicine (IOM), Preventing Low Birthweight, provides guidelines for the type of medical and health services which could improve the quality of prenatal care. The IOM recommends that several specific components of prenatal care be offered to all women. Among these are: (1) patient counseling on potential problems and interventions; (2) formal risk assessment, including psycho-social and medical assessments; (3) ultrasound imaging for diagnostic purposes; (4) management of behavioral risks such as nutrition counseling and therapy, smoking cessation and substance abuse treatments; (5) prenatal and parenting education; and (6) special medical and health services to deal with specific risks, conditions and problems. For infants, based on the American Academy of Pediatrics' guidelines, routine care consists of a minimum of six visits in the first year of life. These visits should include a physician examination, measurement, developmental testing, and immunizations. There will also be a need for care for common illnesses during this time of life. In addition, high risk infants may need more frequent examinations, home visits, vitamin supplementation, prescription drugs, specialized medical or developmental testing, or rehabilitative services. Parents may also require intensive parenting education.

Significant contributions have been made to increase the access to quality health care for low-income and uninsured families by Community and Migrant Health Centers. Begun in 1965 as eight research and demonstration projects, the program has expanded over the past twenty years into 800 primary health care centers providing comprehensive primary care to nearly six million poor and underserved Americans in 50 states, Puerto Rico, and the District of Columbia.

Of those served by Community and Migrant Health Centers, it is estimated that 60 percent are poor, 48 percent lack any form of health insurance, over one-third are children under the age of 14, and over one-third are women of child bearing age.

However, it has been estimated by the Health Resources and Services Administration that the Community and Migrant Health Centers reach less than one fourth of America's 25 million medically underserved residents.

The Community Health Centers (CHC) and Migrant Health (MH) programs were reauthorized in 1986 for fiscal years 1987 and 1988. However, at that time the authorization levels were "frozen" for fiscal years 1987 and 1988 at the same levels as the fiscal year 1986 Congressional appropriations for these programs—that is, at $400.0 million annually for the CHC program and $45.4 million for the MH program.

Section 5, relating to Area Health Education Centers (AHEC), is aimed at improving maternal and child health care in areas particularly hard-hit by maternal and child health problems. This section addresses the tremendous shortage of health care personnel in the area along the U.S.-Mexican border, and the problems of delivery of health care in sparsely populated, rural or "frontier" areas. AHEC programs will be expanded, targeting resources to these especially needy areas in addition to areas with disproportionately high infant mortality rates. The services actually rendered by the AHECs will serve to fill existing gaps in the delivery of maternal and child health care. More lasting benefits will derive by health care professionals who receive training at AHEC sites, and who remain in these needy areas to practice.

III. Text of the Bill as Reported

A BILL To reduce the incidence of infant mortality.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Public Health Service Act Infant Mortality Amendments of 1987".

FINDINGS

Sec. 2. The Congress finds that—

(1) the United States has made far less progress than other industrialized nations in reducing the infant mortality rate;

(2) the Surgeon General in 1980 established the 1990 Health Objectives for the Nation concerning the provision of prenatal care early in pregnancy and for reducing the incidence of low birthweight babies and infant mortality;

(3) the incidence of low birthweight, which is one leading cause of infant mortality and handicapping conditions (such as retardation, cerebral palsy, epilepsy, and autism) has been reduced only marginally;

(4) insufficient progress has been made in the reduction of the overall infant mortality rate;

(5) despite a declining infant mortality rate, black infants remain twice as likely as white infants to die in the first year of life;

(6) it now appears that the Nation will fail to meet the objectives of the Surgeon General described in paragraph (2);

(7) it is well established that appropriate and timely prenatal care and primary care for infants can reduce infant mortality and improve infant health and are essential if the Nation is to meet objectives of the Surgeon General described in paragraph (2);

(8) it is well established that inadequate prenatal care and infant mortality and disability are highest for those individuals who are poor and are without health insurance;

(9) recent statistics indicate that 1 out of every 3 poor children and 1 out of every 3 women of child bearing age does not have health insurance;

(10) community and migrant health centers were established to provide primary health care to poor individuals and individuals without health insurance;

(11) of the individuals served by such centers, 60 percent are poor, 48 percent lack any form of health insurance, over one-third are children under the age of 14, and over one-fourth are women of child bearing age; and

(12) the services of community and migrant health centers should be expanded to provide increased prenatal care and infant care, including an expansion of the number of health professionals providing such services.

MIGRANT HEALTH CENTERS

SEC. 3. Section 329(h)(1) of the Public Health Service Act is amended by striking out "$45,400,000" the second place it appears and inserting in lieu thereof "$48,400,000".

COMMUNITY HEALTH CENTERS

SEC. 4. (a) Section 330(g)(1) of the Public Health Service Act is amended by striking out "$400,000,000" the second place it appears and inserting in lieu thereof "$435,000,000".

(b) Section 330(c) of such Act is amended by adding at the end thereof the following new paragraph:

"(4) In making grants under this subsection and subsection (d), the Secretary shall give special consideration to the unique needs of frontier areas.".

(c) Section 330(g) *of such Act* is amended by adding at the end thereof the following new paragraph:

"(4) In any case in which the amounts appropriated under paragraph (1) for fiscal year 1988 exceed $418,000,000, the total amount of any such excess shall be available for grants under subsections (c) and (d) to community health centers to support special prenatal services to decrease infant mortality and special perinatal coordination projects to develop and coordinate referral arrangements between community health centers and other agencies, institutions, and organizations that are crucial to the successful management of pregnant women and infants. In making grants from amounts available under the preceding sentence, the Secretary shall give priority to community health centers in areas in which there is a high incidence of infant mortality or in which there is an increased incidence of infant mortality.".

AREA HEALTH EDUCATION CENTERS

SEC. 5. (a) Section 781(a)(1) of the Public Health Service Act is amended—

(1) by inserting "(A)" before "The"; and

(2) by adding at the end thereof the following new subparagraph:

"(B) Under subparagraph (A), the Secretary shall enter into contracts to establish and support area health education center programs which include training of personnel to offer maternal health services and child health services in underserved areas. In entering into contracts under the preceding sentence, the Secretary shall give priority to programs which will train personnel to provide such services in areas along the border between the United States and Mexico, in frontier areas, and in areas in which the rate of infant mortality and low birthweight are disproportionately higher than such rates for the State in which such an area is located.".

(b) Section 781(c)(1) of such Act is amended by inserting before the semicolon a comma and "except that a program described in subsection (a)(1)(B) shall only be required to provide for the active participation in such program of individuals who are associated with the administration of the school and each of the departments (or specialties if the school has no departments) of pediatrics, obstetrics and gynecology, and family medicine".

(c) Section 781(c)(2) of such Act is amended by inserting "except in the case of a program described in subsection (a)(1)(B)," before "provide".

(d) Section 781(d)(2)(C) of such Act is amended—

(1) by inserting "(i) except as provided in clause (ii)," before "provide";

(2) by inserting "or" after the semicolon; and

(3) by adding at the end thereof the following new clause:

"(ii) in the case of a program described in subsection (a)(1)(B), provide for or conduct a medical residency program in obstetrics and gynecology in which no fewer than six individuals are enrolled in first year positions in such program;".

(e) Section 781(d)(2)(F) of such Act is amended by striking out "and nurse practitioners" and inserting in lieu thereof ", nurse practitioners, and nurse midwives".

(f) Section 781(g) of such Act is amended—

(1) by striking out "$18,000,000" the last place it appears and inserting in lieu thereof "$21,000,000"; and

(2) by adding at the end thereof the following new sentence: "Of the amounts appropriated under this subsection for fiscal year 1988, $3,000,000 shall be available for contracts under subsection (a)(1)(B).".

FELLOWSHIPS FOR NURSE PRACTITIONERS AND NURSE MIDWIVES

SEC. 6. Part A of title VIII of the Public Health Service Act is amended by adding at the end thereof the following new section:

"FELLOWSHIPS FOR NURSE PRACTITIONERS AND NURSE MIDWIVES

"SEC. 823. (a) The Secretary shall make grants to public or nonprofit private schools of nursing for the establishment and operation of fellowship programs for the education of nurse midwives and pediatric, family, obstetric, and gynecologic nurse practitioners. Such programs shall meet the guidelines prescribed by the Secretary under subsection (b).

"(b) After consultation with appropriate educational organizations and professional nursing and medical organizations, the Secretary shall prescribe guidelines for fellowship programs for the education of nurse midwives and pediatric, family, obstetric, and gynecologic nurse practitioners. Such guidelines shall, as a minimum, require that such a program—

"(1) extend for at least one academic year; and

"(2) consist of—

"(A) supervised clinical practice; and

"(B) at least four months (in the aggregate) of classroom instruction,

directed at preparing nurses to deliver pediatric, family, obstetrical, and gynecological services, particularly prenatal care and other services designed to reduce infant mortality.

"(c) A fellowship funded under this section shall include, for each year for which the fellowship is awarded, 100 percent of the costs of tuition, books, fees, reasonable living expenses (including stipends), reasonable moving expenses, and necessary transportation.

"(d)(1) In order to receive a fellowship funded under this section, an individual must be a registered nurse.

"(2) In awarding fellowships funded under this section, a school of nursing shall give priority to any applicant who—

"(A) is employed by a facility providing health services to medically underserved populations, such as a community health center, a migrant health center, a facility operated by the Indian Health Service, or a Native Hawaiian health center; and

"(B) has been recommended for the fellowship by the facility described in subparagraph (A).

"(e) No grant may be made for the establishment and operation of a fellowship program under this section unless this application for the grant contains assurances satisfactory to the Secretary that the program meets or will meet the guidelines which are in effect under subsection (b).

"(f) For grants under this section, there are authorized to be appropriated $4,000,000 for fiscal year 1988.".

IV. Committee Views

The Committee recognizes that it is well established that appropriate and timely prenatal care and primary care for infants can reduce infant mortality and improve the health of infants. The Committee is concerned about the continued high incidence of infant mortality in our country and is committed to aggressive actions to meet the Surgeon General's 1990 objectives in the area of material and child health. Most notably, those objectives relating to prenatal care improvements, reductions in low birthrate, overall mortality reduction for minorities and postneonatal mortality reductions are of great concern. The Committee recognizes that action is necessary to reduce the thousands of unnecessary low birthweight births and hundreds of preventable infant deaths.

Community and Migrant Health Centers were established to provide primary health care in medically underserved areas and among low-income and minority populations, many of whom have

no health insurance. These centers represent ideal locations for targeting efforts to improve access to prenatal and infant health services for poor and uninsured women and infants.

The purpose of this legislation is to directly contribute to the reduction of perinatal mortality/morbidity rates, improve pregnancy outcomes and enable underserved areas to reach the Surgeon General's 1990 infant health goals by:

Improving pregnant women's and children's access to needed health services;

Enhancing the ability of C/MHCs to provide comprehensive perinatal ambulatory care services;

Enriching the services of C/MHCs through addition of staff for outreach, health care, nutrition education, etc.

Better coordination of services between C/MHC and other local public and private providers of medical, health and health-related services;

Increasing the number of Nurse Practitioners and Certified Nurse Midwives at C/MHCs and underserved areas and at Indian Health Service and Native Hawaiian Center sites; and

Expanding educational programs for medical and health personnel in order to improve their ability to deliver maternal health and child health services.

A. COMMUNITY AND MIGRANT HEALTH CENTERS

The Committee intends that all funds appropriated under this authorization shall be used for efforts which, directly or indirectly, will contribute to reduce maternal, infant and child mortality and morbidity.

1. Grants To Develop New Centers, Expand Existing Sites, and Enhance the Provision of Primary and Supplemental Services

Under the provisions of the bill, the first $18 million in appropriations for CHCs that exceed $400 million, and the appropriations for Migrant Health that exceed $45.4 million, should be for general expansion of the programs through a combination of:

Development of new service delivery systems in identified communities where no C/MHC services now exist;

Expansion of service delivery capacity in existing C/MHCs, to provide delivery of services through expanded or additional sites in identified communities where current services are insufficient to meet needs;

Enhancement of current primary and supplemental services at existing C/MHCs to improve quality and scope of care provided to pregnant women and children; or

Better coordination with other statewide services in order to enhance perinatal delivery systems.

The Committee believes that using these funds to establish new centers or expand existing centers (through the addition of new service sites or new personnel, or both) will improve the availability of comprehensive, high quality maternal and infant care. In many high risk areas of the country, pregnant women are unable to find accessible and affordable prenatal care. Following birth, basic care for an infant's health needs may be even more difficult

to locate. The Committee has special concern about areas of the country and States where infant mortality remains unusually high and there are no community services available. Southern States, border States along the U.S.-Mexican border, and frontier areas are identified by the Committee as areas meriting special attention for establishment of new facilities to improve access to care.

These funds should also be made available to meet the costs of hiring additional medical, nursing, ancillary service, or case management personnel, or the costs associated with deploying staff at additional service sites, in order to better serve high risk pregnant women, infants, and children.

While the bill requires that priority for grants supported with certain funds (those amounts appropriated for CHCs in excess of $418 million) must be given to areas with high or increasing incidence of infant mortality, it is also the Committee's intent that development of new service delivery sites, whether through new starts (new grantees) or expansions (existing grantees) should be limited to identified areas which are medically underserved areas and have a high or increasing rate of maternal, infant, or child health mortality or morbidity, including low birthweight, whether for the general population or for population subgroups (racial or ethnic minorities, those with below-poverty incomes, or the like).

For purposes of this act, a high incidence of infant mortality is considered to be a rate which is greater than the infant mortality rates for the Nation, either as a whole or by race. In 1984, these rates were 10.8 infant deaths per 1,000 live births for all races, 9.4 per 1,000 for whites, and 18.4 per 1,000 for blacks. The Secretary, in making grants to projects serving other populations, such as Native Americans or Hispanics, should apply appropriate mortality rates as developed by the National Center for Health Statistics for infants from each special racial and ethnic minority. The Secretary should also give special consideration to areas in which the neonatal (birth to 28 days) or postneonatal (29 days to one year) infant mortality rates are higher than average, even though the overall infant mortality rate may be at or below the national average and to areas with high concentrations of minority populations other than blacks. The Secretary should also give special consideration to areas which may be below overall the national average, but which have seen a dramatic increase in the incidence of infant mortality in recent periods.

Some communities may have a high concentration of Hispanic, Native American, Alaskan Native or Asian mothers and infants who may have increased health risks demonstrated through specialized studies. In these cases, the Secretary should consider racially and culturally appropriate statistics and special studies in prioritizing grant allocations. The Secretary is also directed to compare infant mortality rates presented in any grant proposal to appropriate racial and ethnic group rates.

While the Committee expects these new funds to assist high risk pregnant women, infants, and children, the Committee does not intend exclusive services must be provided to these populations by new programs established through this funding. The Committee agrees that through general enrollment, new C/MHC sites will be

providing care to a significant number of pregnant women and children.

Further, it is the Committee's intent that the Secretary make grants designed to enhance the scope and depth of primary and supplemental services offered by centers pursuant to Sections 329 and 330 of the Act. This is especially important in the case of high risk pregnant women and infants because the development of new technology and risk assessment techniques has dramatically outstripped centers' service capacity and grant levels. The Committee also intends that centers have the latitude to use these enhancement funds toward meeting their maternity and infant patients' hospitalization needs when, in the opinion of the centers, hospitalization is essential to patient management and other resources are unavailable.

2. Grants To Provide Outreach and Patient Management and Assistance Services and To Engage in Perinatal Coordination

The Committee supports outreach, and patient management and assistance services in a broad effort to reduce infant mortality. Enhanced medical care through new sites and additional personnel are fundamental to reduce infant mortality. In the case of low-income and racially, geographically, ethnically, and culturally isolated families, moreover, it involves aggressive efforts to coordinate a smoothly functioning perinatal and infant care system in which the range of agencies, institutions and providers serving the population can work smoothly together with common goals.

Therefore, the Committee intends that amounts appropriated over $418 million be used to fund outreach and patient management services as well as special perinatal/infant coordination projects between health centers and other agencies, institutions, and organizations that are crucial to successful management of pregnant women and infants.

The Committee intends that funds in excess of $418 million be used for outreach, patient management services and care. These services are defined as activities designed to get women and children into care as early as possible, keep them in care, and make the care system responsive to their needs. Specific services (many of which are already recognized as primary and supplemental services) include:

Casefinding, including the use of lay and professional outreach workers;

Translation assistance as well as other activities that reduce barriers to care such as transportation and child care;

Patient and provider education regarding what medical and health services, assistance and resources are available in a community and how to gain access to them;

Parenting and perinatal patient education classes; and

Coordination of services with other perinatal care providers.

The Committee recognizes that these services can best be provided through employment of additional staff, especially lay outreach workers, and through the development of a "team approach", involving such outreach workers and the centers' clinical staff. It is the provision of these types of services which has made the C/MCH

programs unique and particularly successful in effectively caring for high risk, medical underserved populations.

In addition, the Committee supports funding of up to $3 million of the additional funds for centers to improve the quality and responsiveness of regionalized perinatal care services for their patients. Centers might accomplish these objectives through a variety of activities. These might include: developing or upgrading transportation systems which would be suitable for high risk mothers and infants; training staff to provide better risk assessment, more appropriate referral, or better follow-up care; developing improved communication systems between centers and more specialized medical centers; providing prenatal outreach to better ensure timely entry into appropriate care; and developing a system for accelerated eligibility into public programs such as the Supplemental Food Program for Women, Infants and Children (WIC), Medicaid, and other indigent health care financing programs. These grants would be used to develop coordination and referral arrangements between health centers and other agencies, institutions and organizations within their communities that are crucial to the successful management of pregnant women and infants.

Additionally, centers might use funding to develop coordinated delivery and hospital admission programs so that pregnant patients who need high risk delivery services can be moved quickly and smoothly into specialized delivery settings.

The Committee believes that while the basic grant program will permit health centers located in high mortality areas to upgrade, improve and strengthen their own services, there will be women and children whose needs simply exceed the level of care that centers are equipped to furnish. This special supplemental grant program will permit centers to establish programs, standards and referral systems with other segments of the community, for ensuring prompt high quality care when such specialized interventions are warranted.

Because of the continuing problems of perinatal mortality and morbidity, it is the Committee's intent that additional funding for these activities be made available as soon as possible. Therefore, the Committee urges the establishment of a streamlined application and approval process with minimal reporting requirements. In this way, grant funding can be expedited and services made available in a timely basis.

Furthermore, the Committee does not intend that these funds be subject to formal demonstration evaluation procedures. However, in order to evaluate the success of these programs in reducing the incidence of infant mortality, the Committee intends, at a minimum, that the following data be collected: (1) the number of women and infants served; (2) in the case of pregnant women, the trimester of initiation of prenatal care; and (3) the conditions disclosed among pregnant women and infants served. These statistics should be reported to the Secretary annually, in conjunction with other reports already required of CHC and MH grantees. The Secretary shall, in turn, compile the data from various projects and issue a public report.

The Committee is hopeful that these activities will continue and expand through future considerations of the Community and Migrant Health Center legislation.

3. Frontier Areas

During the past year, as the public policy debate of the problems of financing and delivering health care services in rural areas has unfolded, the Committee has become aware of the special problems inherent in attempting to develop and operate health care delivery systems in the most sparsely populated rural areas of America. Borrowing from a DHHS-funded Task Force, the Committee has used the term "frontier" to describe these areas, which are defined as those with a population density of no more than six persons per square mile, spread over a broad geographical area (generally an entire county or multiple counties, although a sub-county area or adjoining parts of two or more counties would also fit this definition).

According to the 1980 U.S. Census, there were at least 382 counties, with a population of nearly 2.9 million persons, which would meet the above definition. These areas are principally found in 20 Western states, and encompass 45 percent of the U.S. land area.

In addition to having sparse population, these areas tend to be geographically isolated, have a fragile economic base and offer limited health services. The geographic isolation and population sparcity of such areas mitigate against traditional approaches to development and efficient operation of ambulatory health care delivery systems. The small size of such systems results in inherent cost inefficiencies, decreased productivity of clinical providers, difficulty in arranging referrals, and difficulties in recruiting and retaining high quality clinical and management personnel.

Despite the fact that most of the residents of the areas are obviously medically underserved, very few CHCs (or even free-standing National Health Service Corps sites) are currently receiving federal support in such areas. In fiscal year 1986, only 17 of the 648 CHC grantees were located in frontier areas as were 38 of 3,127 NHSC assignees. Moreover, the federal expectations and requirements of these sites were the same as those for much larger rural, and even urban, CHC sites. Although the statute permits considerable latitude in designing appropriate CHC systems, the federal program managers appear to have allowed little or no flexibility in permitting grantees to tailor their delivery systems to local needs or to the unique characteristics of these areas.

To remedy this situation, the Committee intends the Secretary to:

Facilitate and support development of grant applications from frontier areas through use of federal technical assistance resources and appropriate state governmental entities and state associations of CHCs, supported under Section 330(f)(1).

Ensure that applications for grant support (whether for planning and development or for operations) are accorded fair and equitable treatment by federal reviewing authorities.

Develop criteria, standards, expectations and requirements for frontier sites which are relevant to their unique operational nature and are different from those for larger operations.

Within statutory limitations, explicitly allow and encourage creative approaches to systems development and operations.

Support and facilitate continued research, data development and efforts to promote a better understanding of the needs of frontier areas, including the work of the Frontier Health Task Force.

The Committee wishes to clarify that it in no way intends to require the Secretary to ignore or waive current statutory requirements in this regard, nor does it expect the Secretary to support systems of care which are inadequate with respect to quality of care or completeness of care. For example, all frontier area CHCs must serve medically underserved populations and must meet the statute's requirements for governance, administration, fiscal and clinical systems and accountability, and the like. At the same time, such CHCs should be expected to make extensive use of mid-level providers, and to provide some services by referral arrangement rather than directly.

B. AREA HEALTH EDUCATION CENTERS (AHEC) PROGRAM

An adequate supply of well trained health care professionals is crucial to the delivery of medical care, including essential prenatal and postnatal care. The Committee recognizes both this fundamental principle and the shortage of health care professionals in underserved areas along the border with Mexico, and in sparsely populated frontier areas.

Section 5 addresses this shortage and seeks to alleviate it by providing for an expansion of the Area Health Education Center (AHEC) program, and by targeting additional resources to Florida and other Southern States, the Pacific Basin region, the area along the Mexican border and frontier areas. The Committee intends for the additional funding to be used to establish new AHECs and expand existing centers to increase and improve the delivery of prenatal and postnatal care in these targeted areas, and in areas with disproportionately high rates of infant mortality.

The AHEC program can play a crucial role in improving health care in these identified shortage areas in at least two important ways. First, the sensitivity of health care professionals to the needs of shortage areas should improve as physicians in training receive valuable experience in AHECs located in or serving shortage areas. Second, providing for training of health care professionals in shortage areas may increase the likelihood that these professionals will choose to practice there, and provide greater access to the needed medical care. The Committee expects those AHECs that receive funding under this section to work closely with C/MHCs, Indian Health Service facilities, and other providers serving the area, and with the statewide organizations representing the centers and other providers, in designing and implementing these new initiatives.

C. FELLOWSHIPS FOR NURSE PRACTITIONERS AND NURSE MIDWIVES

The bill establishes a new program to support the granting of fellowships for the education of nurse midwives and pediatric, family,

obstetric and gynecologic nurse practitioners, authorized at $4 million for fiscal year 1988.

There is a chronic shortage of health care professionals willing to provide high quality services to low income, high risk mothers and infants in rural, inner city, and other underserved areas. Often this shortage can be reduced by increasing the number of nurse practitioners (NP) and nurse midwives (NM) to serve in these areas. An Office of Technology Assessment report recently documented that within areas of competence, NPs and NMs provide care whose quality is equivalent to that of care provided by physicians. The report also credited NPs and NMs with improving the geographic distribution of care because many of them have been willing to locate in underserved rural and inner city areas. The Committee recognizes the critical importance of such practitioners to the success of the expanded perinatal care effort. At the same time, the Committee is concerned with the recent steep decline in the number of students in NP/NM training programs.

Under this new program, grants are to be made to schools of nursing for the establishment of fellowship programs, to assist individuals to meet the cost of educational and living expenses incurred while they are students in the NP or NM training programs. The Secretary is required to prescribe guidelines for such fellowship programs, in consultation with appropriate educational and professional organizations. The Committee does not expect such guidelines to be excessive or burdensome, or to require significant alterations to existing accredited NP and NM educational programs. It is expected that those NPs and NMs assigned to the Native Hawaiian health centers, funded jointly by HRSA and the Kamehameha Schools/Bishop Estate will themselves be Native Hawaiians whenever possible.

Priority for such fellowships is to be given to registered nurses who:

Are employed by CHC and MHC grantees, or by Indian Health Service facilities or Native Hawaiian health centers;

Have been recommended for the fellowships by their employers; and

Agree to return to their employer following completion of NP or NM training and to remain there for a period of time at least equal to the length of their training or education program.

The clear intent of the Committee is to assist the health centers and other facilities to upgrade the capabilities of their staffs, in conjunction with the other activities authorized in the bill. Although the bill would not authorize the extention of salaries of applicants during their training period, the Committee understands that stipends may need to be provided by employers.

V. Committee Action

S. 1441 was introduced in the Senate on June 26, 1987, and referred to the Committee on Labor and Human Resources. The Committee met in executive session on July 1, 1987, and agreed unanimously to report S. 1441 to the Senate.

VI. Congressional Budget Office Cost Estimate

U.S. Congress,
Congressional Budget Office,
Washington, DC, July 29, 1987.

Hon. Edward M. Kennedy,
Chairman, Committee on Labor and Human Resources.
U.S. Senate, Washington, DC.

Dear Mr. Chairman: The Congressional Budget Office has prepared the attached cost estimate for S. 1441, the Public Health Service Act Infant Mortality Amendments of 1987, as ordered reported by the Senate Committee on Labor and Human Resources on July 1, 1987.

If you wish further details on this estimate we will be pleased to provide them.

With best wishes,
Sincerely,

Edward M. Gramlich,
Acting Director.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE, JULY 29, 1987

1. Bill number: S. 1441.
2. Bill title: Public Health Service Act Infant Mortality Amendments of 1987.
3. Bill status: As ordered reported by the Senate Committee on Labor and Human Resources on July 1, 1987.
4. Bill purpose: To reduce the incidence of infant mortality.
5. Estimated cost to the Federal Government:

[By fiscal years, in millions of dollars]

	1988	1989	1990	1991	1992
Estimated authorization levels:					
Migrant Health Centers	3	—	—	—	—
Community Health Centers	35	—	—	—	—
Area Health Education Centers	3	—	—	—	—
Fellowships for nurse practitioners and nurse midwives	4	—	—	—	—
Total authorization level	45	—	—	—	—
Total estimated outlays	24	15	5	1	—

The costs of this bill would fall within budget function 550.

Basis of estimate: This bill would increase the fiscal year 1988 authorization levels for the migrant health centers, community health centers, and area health education centers programs. The table below shows the current 1988 authorization levels for these programs compared to the levels proposed in S. 1441.

[In millions of dollars]

	1988 current	1988 proposed	Increase
Authorization levels:			
Migrant Health Centers	45.4	48.4	3
Community Health Centers	400	435	35
Area Health Education Centers	18	21	3
Total	463.4	504.4	41

All authorization levels are specified in the bill. Outlays are estimated using spendout rates calculated by CBO on the basis of similar health service spending data.

6. Estimated cost to State and local government: Schools receiving federal support for area health education centers must provide 25 percent of their funds from nonfederal sources. If the additional $3 million is appropriated in fiscal year 1988, schools would have to provide an additional $1 million in nonfederal funds. This money could come from state or local governments.

7. Estimate comparison: None.

8. Previous CBO estimate: None.

9. Estimate prepared by Carmela Dyer.

10. Estimate approved by C.G. Nuckols, for James L. Blum, Assistant Director for Budget Analysis.

VII. Regulatory Impact Statement

The Committee has determined that there will be minimal or no increase in the burden of paperwork or additional regulation imposed by this bill.

VIII. Section-by-Section Analysis

Section 1 cites the title of this bill as the "Public Health Service Act Infant Mortality Amendments of 1987", and states the purpose of this legislation, to reduce the incidence of infant mortality.

Section 2 contains findings related to: the serious problems of infant mortality and morbidity on the United States; the failure of the U.S. to achieve significant reductions in the incidence of infant mortality and morbidity and the likelihood that the U.S. Surgeon General's 1990 Health Objectives for the Nation will not be achieved; the importance of expanding access to high quality medical and health care—especially for high risk pregnant women, infants and children—in order to successfully impact on infant mortality and morbidity; and the vital role Community and Migrant Health Centers can play in this effort.

Section 3 amends Section 329(h)(1) of the PHS Act to increase the fiscal year 1988 authorization for the Migrant Health programs by $3 million, from $45.4 million to $48.4 million.

Section 4(a) amends Section 330(g)(1) of the PHS Act to increase the fiscal year 1988 authorization for the Community Health Centers program by $35 million, from $400 million to $435 million.

Section 4(b) amends Section 330(c) of the PHS Act to require the Secretary to give special consideration to the unique needs of frontier areas in making grants under the CHC program.

Section 4(c) amends Section (g) of the PHS Act to require that, for fiscal year 1988, amounts appropriated for the CHC program

which exceed $418 million shall be used to support the cost of delivering special prenatal services designed to reduce infant mortality, and for grants to support special prenatal coordination projects to improve the coordination and delivery of all medical, health and related services for pregnant women and infants, with a priority for areas with high or increasing infant mortality rates.

Section 5 amends Section 781 of the PHS Act to establish a new effort within the Area Health Education Centers (AHEC) program, authorizing grants for the establishment and support of AHEC programs for the training of health personnel to offer maternal and child health services in underserved areas. The bill would increase the fiscal year 1988 authorization level for the AHEC program by $3 million, from $18 million to $21 million, and require that, of amounts appropriated for the AHEC program in FY 1988, $3 million shall be spent for this new effort.

The bill would require the Secretary, in making grants for this new effort, to give priority to programs that will train personnel to provide maternal and child health services along the U.S.-Mexico border, in designated frontier areas, and in areas with disproportionately higher infant mortality and low birthweight rates, when compared with other areas of the state(s) in which the program would operate.

The bill would also permit, under this new effort, the use of grant funds to support medical residency programs in obstetrics and gynecology with at least six first-year residents, and for the training of nurse midwives, as well as nurse practitioners.

Section 6 amends Part A of Title VIII of the PHS Act to add a new Section 823 establishing a new program of Fellowships for Nurse Midwives. Under this new program, grants could be made to public or nonprofit private schools of nursing for the establishment and operation of fellowship programs to train qualified individuals as nurse midwives or a pediatric, family, obstetric or gynecologic nurse practitioners. Such programs must extend for at least one academic year, and must include supervised clinical practice and at least four months of classroom instruction. The fellowship programs must give priority to applicants who are employed by facilities that provide health services to medically underserved populations, such as CHC's and MMHC's, Indian Health Service facilities or Native Hawaiian health centers, and who have been recommended by their employers for fellowships assistance. The bill authorizes the appropriations of $4 million for fiscal year 1988 for such fellowships.

IX. Changes in Existing Law

In compliance with rule XXVI paragraph 12 of the Standing Rules of the Senate, the following provides a print of the statute or the part or section thereof to be amended or replaced (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic existing law in which no change is proposed in shown in roman):

Public Health Service Act

* * * * * * *

TITLE III—GENERAL POWERS AND DUTIES OF PUBLIC HEALTH SERVICE

* * * * * * *

PART D—PRIMARY HEALTH CARE

Subpart I—Primary Health Centers

MIGRANT HEALTH

SEC. 329. * * *

(h)(1) For the purposes of subsections (c), (d), and (e), there are authorized to be appropriated $43,000,000 for the fiscal year ending September 30, 1982, $47,500,000 for the fiscal year ending September 30, 1983, $51,000,000 for the fiscal year ending September 30, 1984, $45,400,000 for fiscal year 1987 and [$45,400,000] *$48,400,000* for fiscal year 1988. The Secretary may not obligate for grants and contracts under subsection (c)(1) in any fiscal year an amount which exceeds 2 per centum of the funds appropriated under this paragraph for that fiscal year, the Secretary may not obligate for grants under subsection (d)(1)(C) in any fiscal year an amount which exceeds 5 per centum of such funds, and the Secretary may not obligate for contracts under subsection (e) in any fiscal year an amount which exceeds 10 per centum of such funds.

* * * * * * *

COMMUNITY HEALTH CENTERS

SEC. 330. * * *

(c)(1) The Secretary may make grants to public and nonprofit private entities for projects to plan and develop community health centers which will serve medically underserved populations. A project for which a grant may be made under this subsection may include the cost of the acquisition and modernization of existing buildings (including the costs of amortizing the principal of, and paying the interest on, loans) and shall include—

(A) an assessment of the need that the population proposed to be served by the community health center for which the project is undertaken has for primary health services, supplemental health services, and environmental health services;

(B) the design of a community health center program for such population based on such assessment;

(C) efforts to secure, witin the proposed catchment area of such center, financial and professional assistance and support for the project; and

(D) initiation and encouragement of continuing community involvement in the development and operation of the project.

(2) Not more than two grants may be made under this subsection for the same project.

(3) The amount of any grant made under this subsection for any project shall be determined by the Secretary.

(4) In making grants under this subsection and subsection (d), the Secretary shall give special consideration to the unique needs of frontier areas.

* * * * * * *

(g)(1) There are authorized to be appropriated for payments pursuant to grants under this section $400,000,000 for fiscal year 1987 and [$400,000,000] *$435,000,000* for fiscal year 1988.

(2) The Secretary may not in any fiscal year—

(A) expend for grant sto serve medically underserved populations designated under subsection (b)(6) an amount which exceeds 5 percent of the funds appropriated under this section for that fiscal year; and

(B) expend for grants under subsection (d)(1)(C) an amount which exceeds 5 percent of the funds appropriated under this section for that fiscal year.

(3) The Secretary may not expend in any fiscal year, for grants under this section to public centers (as defined in the second sentence of subsection (e)(3)) the governing boards of which (as described in subsection (e)(3)(G)(ii)) do not extablish general policies for such centers, an amount which exceeds 5 per centum of the funds appropriated under this section for that fiscal year.

(4) In any case in which the amounts appropriated under paragraph (1) for fiscal year 1988 exceed $418,000,000, the total amount of any such excess shall be available for grants under subsections (c) and (d) to community health centers to support special prenatal services to decrease infant mortality and special perinatal coordination projects to develop and coordinate referral arrangements between community health centers and other agencies, institutions, and organizations that are crucial to the successful management of pregnant women and infants. In making grants from amounts available under the preceding sentence, the Secretary shall give priority to community health centers in areas in which there is a high incidence of infant mortality or in which there is an increased incidence of infant mortality.

* * * * * * *

TITLE VII—HEALTH RESEARCH AND TEACHING FACILITIES AND TRAINING OF PROFESSIONAL HEALTH PERSONNEL

* * * * * * *

AREA HEALTH EDUCATION CENTERS

SEC. 781. (a)(1)*(A)* The Secretary shall enter into contracts with schools of medicine and osteopathy for the planning, development, and operation of area health education center programs.

(B) Under subparagraph (A), the Secretary shall enter into contracts to establish and support area health education center programs which include training of personnel to offer maternal health services and child health services in underserved areas. In entering into contracts under the preceding sentence, the Secretary shall give priority to programs which will train personnel to provide such services in areas along the border between the United States and Mexico, in frontier areas, and in areas in which the rate of infant

mortality and low birthweight are disproportionately higher than such rates for the State in which such an area is located.

* * * * * * *

(c) Each medical or osteopathic school participating in an area health education center program shall—

(1) provide for the active participation in such program by individuals who are associated with the administration of the school and each of the departments (or specialties if the school has no such departments) of internal medicine, pediatrics, obstetrics and gynecology, surgery, psychiatry, and family medicine, *except that a program described in subsection (a)(1)(B) shall only be required to provide for the active participation in such program of individuals who are associated with the administration of the school and each of the departments (or specialties if the school has no departments) of pediatrics, obstetrics and gynecology, and family medicine;*

(2) *except in the case of a program described in subsection (a)(1)(B),* provide that no less than 10 percent of all undergraduate medical or osteopathic clinical education of the school will be conducted in an area health education center and at locations under the sponsorship of such center;

* * * * * * *

(d)(1) Each area health education center shall specifically designate a geographic area in which it will serve, or shall specifically designate a medically underserved population it will serve (such are or population with respect to such center in this section referred to as "the area served by the center"), which area or population is in a location remote from the main site of the teaching facilities of the school which participate in the program with such center.

(2) Each area health education center shall—

(A) provide for or conduct training in health education services, including education in nutrition evaluation and counseling, in the area served by the center;

(B) assess the health manpower needs of the area served by the center and assist in the planning and development of training programs to meet such needs;

(C)*(i) except as provided in clause (ii)* provide for or conduct a rotating osteopathic internship or a medical residency training program in family medicine, general internal medicine, or general pediatrics in which no fewer than six individuals are enrolled in first-year positions in such program; *or*

(ii) in the case of a program described in subsection (a)(1)(B), provide for or conduct a medical residency program in obstetrics and gynecology in which no fewer than six individuals are enrolled in first year positions in such program;

* * * * * * *

(F) conduct interdisciplinary training and practice involving physicians and other health personnel including, where practi-

cable, physician assistants [and nurse practitioners], *nurse practitioners, and nurse midwives;*

* * * * * * *

(g) There are authorized to be appropriated to carry out the provisions of this section $20,000,000 for the fiscal year ending September 30, 1978, $30,000,000 for the fiscal year ending September 30, 1979, $40,000,000 for the fiscal year ending September 30, 1980, $21,000,000 for the fiscal year ending September 30, 1982, $22,500,000 for the fiscal year ending September 30, 1983, $24,000,000 for the fiscal year ending September 30, 1984, $18,000,000 for the fiscal year ending September 30, 1986, $18,000,000 for the fiscal year ending September 30, 1987, and [$18,000,000] *$21,000,000* for the fiscal year ending September 30, 1988. The Secretary shall obligate not more than 10 percent of the amount appropriated under this subsection for any fiscal year for contracts under subsection (a)(2).

Of the amounts appropriated under this subsection for fiscal year 1988, $3,000,000 shall be available for contracts under subsection (a)(1)(B).

* * * * * * *

TITLE VIII—NURSE EDUCATION

PART A—SPECIAL PROJECTS

SECS. 820–822.* * *

FELLOWSHIPS FOR NURSE PRACTITIONERS AND NURSE MIDWIVES

SEC. 823. (a) The Secretary shall make grants to public or nonprofit private schools of nursing for the establishment and operation of fellowship programs for the education of nurse midwives and pediatric, family, obstetric, and gynecologic nurse practitioners. Such programs shall meet the guidelines prescribed by the Secretary under subsection (b).

(b) After consultation with appropriate educational organizations and professional nursing and medical organizations, the Secretary shall prescribe guidelines for fellowship programs for the education of nurse midwives and pediatric, family, obstetric, and gynecologic nurse practitioners. Such guidelines shall, as a minimum, require that such a program—

(1) extend for at least one academic year; and

(2) consist of—

(A) supervised clinical practice; and

(B) at least four months (in the aggregate) of classroom instruction,

directed at preparing nurses to deliver pediatric, family, obstetrical, and gynecological services, particularly prenatal care and other services designed to reduce infant mortality.

(c) A fellowship funded under this section shall include, for each year for which the fellowship is awarded, 100 percent of the costs of tuition, books, fees, reasonable living expenses (including stipends), reasonable moving expenses, and necessary transportation.

(d)(1) In order to receive a fellowship funded under this section, an individual must be a registered nurse.

(2) In awarding fellowships funded under this section, a school of nursing shall give priority to any applicant who—

(A) is employed by a facility providing health services to medically underserved populations, such as a community health center, a migrant health center, a facility operated by the Indian Health Service, or a Native Hawaiian health center; and

(B) has been recommended for the fellowship by the facility described in subparagraph (A).

(e) No grant may be made for the establishment and operation of a fellowship program under this section unless this application for the grant contains assurances satisfactory to the Secretary that the program meets or will meet the guidelines which are in effect under subsection (b).

(f) For grants under this section, there are authorized to be appropriated $4,000,000 for fiscal year 1988.

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Calendar No. 257

100TH CONGRESS
1st Session

SENATE

REPORT
100-141

THE COMPREHENSIVE CHILD DEVELOPMENT CENTERS ACT

AUGUST 3 (legislative day, JUNE 23), 1987.—Ordered to be printed

Mr. KENNEDY, from the Committee on Labor and Human Resources, submitted the following

REPORT

[To accompany S. 1542]

The Committee on Labor and Human Resources, to which was referred the bill (S. 1542) to amend the Head Start Act to provide for the establishment of several comprehensive child development centers designed to encourage intensive, comprehensive, integrated and continuous supportive services for infants and young children from low-income families which will enhance their physical, social, emotional, and intellectual development and provide support to their parents, and for other purposes, having considered the same, reports favorably thereon without amendment and recommends that the bill do pass.

I. INTRODUCTION

On July 22, 1987, the Committee on Labor and Human Resources ordered reported an original bill, S. 1542, to the full Senate. The bill was reported unanimously. The bill was sponsored by Senator Edward M. Kennedy, Chairman of the Committee, and co-sponsored by Senators Matsunaga, Simon, Dodd, Harkin, Adams, Weicker, Stafford, Mikulski, Pell, Metzenbaum, and Bingaman.

S. 1542 may be cited as the Comprehensive Child Development Centers Act of 1987. This bill amends the Head Start Act in order to authorize the establishment of Child Development Centers which will provide early, comprehensive and continuous services to economically disadvantaged children. The Centers must provide services beginning at the pre-natal period and extending until the child reaches compulsory school age. The goal is to prevent educa-

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tional failure by addressing the medical, psychological, institutional, and social needs of infants, young children and their parents. The bill is also intended as a preventative measure to reduce the likelihood that young children will be caught in a cycle of poverty.

II. Background and Need

The number of disadvantaged children in American society is increasing rapidly. According to some recent evidence:

Forty percent of the poor in America are children.

Twenty-four percent of all children live below the poverty line.

Nearly sixty percent of children born in 1984 will live with one parent before age eighteen.

In some cities, half of the children born in 1984 will live in poverty before reaching the age of eighteen.

This increase in poverty has wide-ranging consequences. Not only do poor children face greater health and nutritional risks than their more advantaged peers, they are also more likely to experience poor school performance and behavior problems and thus face the possibility of lost educational, social, and intellectual opportunities. These losses are not limited to the childhood years. Addressing the problems of economically disadvantaged children is complicated because the children are usually part of a family that is also disadvantaged. According to one recent study, "these families usually have multiple and interacting social, cultural, economic and physical problems which prevent them from achieving, a satisfactory level of functioning." Children born into disadvantaged families are often further disadvantaged because their parents may be unable to provide the optimum care and nourishment. Too often childhood poverty foreshadows a lifetime of poverty and dependency. For policymakers the choice is clear: either ameliorate the effects of poverty for those who are born into it or deal with the consequences when they are adults.

Public policy efforts to improve the prognosis for children from high-risk environments have been commonplace since the 1930s. Nursery school programs with broad goals of raising parent morale as well as improving the health and nutritional status of children were implemented under the Works Projects Administration. Greater emphasis on boosting the educational attainment of these children soon followed. A number of early intervention programs, most notably Head Start, were launched during the 1960s as part of the War on Poverty. The results of these early initiatives illustrated that early childhood programs were beneficial for all children, but that the effects are most profound for children living in poverty.

In recent years, evidence has continued to mount that carefully designed early-intervention efforts can yield productive returns. This evidence is based on both the results from well-designed small-scale research projects and on the data from large scale demonstration projects. This evidence, coupled with the growing problem of childhood poverty, has convinced the Committee on Labor and Human Resources to authorize a multi-year project designed to encourage intensive and comprehensive support services to chil-

dren and their families living in extremely poor areas. The goal is to prevent educational failure by addressing the medical, psychological, nutritional and social needs of infants and young children. By investing resources in this fashion, we will assure that the children will be fully prepared to enter kindergarten and increase the likelihood that their school years will be productive.

The evidence from well designed research studies show that high-quality programs with specific components, including family involvement, help improve the odds for children from low-income families. Research projects such as the Yale Child Welfare Research Program and the Clinical Infant Development Program provide clear evidence that both short and long-term developmental gains can be expected when coordinated comprehensive services are provided to infants. Other research shows that parenting groups can become vehicles for new social growth for mothers. The sharing of experiences provides a catalyst for adult personality growth, which, when channeled effectively, helps the mothers and fathers be more responsive to their infants.

In 1979, the General Accounting Office (GAO) reviewed a variety of developmental programs for low-income children and concluded that the programs provided lasting, significant gains. More recently, a study by the High/Scope Educational Research Foundation found that a high quality pre-school program resulted in fewer high school dropouts, increased post secondary education participation, fewer detentions and arrests, reduced teenage pregnancy rates, less welfare usage, and increased employment.

If there is a central theme to the research that has been completed, it is that early childhood programs for low income children should begin as early as possible in the child's life, should address a broad range of needs, and should continue until the child starts school. Programs must begin early because the first few years of a child's life have an enormous impact on personality formation, including the development of logical and linguistic skills, emotional balance, and the ability to establish social relationships. A comprehensive approach to the child and his environment recognizes that education alone is not enough: the inter-relationships between early environmental deprivation and later health, social, nutritional and academic problems are clear. It is impossible to improve educational outcomes without addressing other pressing problems that affect a child's ability to learn and grow. Finally, sustained assistance over a period of several years reinforces the advances made by the children and their families throughout the early developmental periods.

The federal government has long recognized the need for early intervention programs to help improve the life chances of low-income children. The most important expression of federal interest—the Head Start program—is now more than twenty years old. Head Start provides funds for a broad range of services for low-income children and their parents. The program was designed to test whether improving children's social and learning skills and health status, while involving parents as much as possible, would help the children break the cycle of poverty. Head Start's success in demonstrating the value of high-quality early childhood initiatives is well-known. The program has survived in a period of

budget cuts, has been the subject of many favorable studies, and is often cited as an example of a successful federal program.

Head Start is effective, but more remains to be done. Head Start programs generally serve children from ages three to five and available research suggests that child development services are most effective when they begin earlier. Fortunately, Head Start has provided us with successful models for early childhood programs with the Parent-Child Centers (PCCs) and the Child and Family Resource Centers programs.

The Parent-Child Centers have offered comprehensive child development and family support services for low-income families since 1967. The PCC projects provide a range of comprehensive services that improve the overall developmental progress of at-risk children, strengthen the parents' skills and understanding of parenting, and reinforce the institution of the family. Intended for children from birth through age 3, the PCCs are encouraged to use innovative approaches. Thus, the programs vary in terms of the number of days per week and hours per day they operate, the services provided, and their program designs. There are 36 centers, located in twenty-eight states, that provide services for approximately 4,500 children and their families.

The Child and Family Resource Program (CFRP) was funded as a Head Start Demonstration from 1973 through 1983. The program was intended to enhance child development by: (1) helping the child by helping the family, (2) focusing on developmental continuity through the early stages of the child's growth, (3) coordinating the delivery of comprehensive family services, and (4) developing individualized plans for services based on assessments of family strengths and needs. Like the PCCs, the CFRP was intended to test different models. However, all CFRPs had a home visiting program for families with infants aged 0 to 3, with complementary center based activities. Participating children transferred to affiliated Head Start programs after age 3. Services continued to follow participating children until age 8. There was considerable variety among the programs, with differing frequency, focus and content of home visits, varying levels of integration with the affiliated Head Start programs, and a variety of professional support beyond the family workers.

A similar progam, this one launched by the private sector, is the Beethoven project undertaken in Robert Taylor Homes, a Chicago housing project. This project will provide intensive and comprehensive support services to all of the children born after January 1, 1987 in the six buildings of the Robert Taylor Homes which comprise the catchment area for the Beethoven Elementary School. The project will provide complete prevention services to the children in an effort to avoid conditions which are likely to lead to later, more intractable problems. The services offered by this project will include: health services (including pre- and post-natal care), infant screening, a family drop-in center, community information sharing and public education, home visitors referrals, home day care providers, Head Start, and a program of collaboration among existing state and local social service efforts. The Beethoven project goes further than any other prevention program. It is the first effort that seeks to ensure that every child entering kinder-

garten at a specific school will be fully prepared for school and thus able to take full advantage of the educational system.

The Comprehensive Child Development Centers Act builds on the successful elements of these programs and the available research evidence. Projects funded under this law must: (1) intervene as early as possible in the child's life, (2) involve the whole family, (3) provide comprehensive services to address a wide range of needs, and (4) provide continuous services from birth to the age of compulsory school attendance. Programs may, at their discretion, serve children of any age between birth and compulsory school age. There is no single model or design intended for the local projects. The Committee intends that sponsors will, within the framework laid out by the law, design projects that best meet local needs and conditions.

Under this act, the Secretary of Health and Human Services is authorized to enter into contracts with eligible agencies to establish Comprehensive Child Development Centers. At least 10 centers are to be funded, but not more than 25. The Secretary is to ensure that at least several of these projects are located in rural areas. Recognizing that the number and quality of applications will vary, the Committee decided not to specify a number of rural based projects. However, the Committee intends that a reasonable number of funded centers will be located in rural communities.

A wide range of agencies are eligible to establish Comprehensive Child Development Centers. According to the law, eligible agencies include a Head Start agency, any community-based organization, an institution of higher education, a public hospital, a community development corporation, or any other public or private non-profit agency or organization specializing in delivering social services to young children. The Committee is less concerned with the precise type of agency that submits an application than it is with the experience and/or potential the agency has in working with community groups in the delivery of services to younger children. Clearly Head Start agencies are eligible and experienced in this regard, but the Committee intends that a substantial number of other organizations will also be funded. However, the Committee also intends that organizations not currently administering a Head Start program must design a program that includes components modeling the PCCs, CFRP and the traditional Head Start program.

In submitting an application, potential CCDCs must describe the target population and the services to be provided. The agency must provide assurances that a comprehensive array of services will be available. For infants and young children, the required services must include, but are not limited to: infant and child health services; child care; early childhood development programs; early intervention services for children with or at-risk of developmental delays; and nutrition services. For parents and other family members, services must include to: prenatal care; education in infant and child development, health nutrition, and parenting; referral for education, employment counseling and training, assistance in securing other basic social services.

The Committee recognizes that few agencies will (or should) attempt to provide such a comprehensive array of services themselves. Thus, applicants are required to describe the extent to

which they will coordinate and utilize service existing locally. The intention is that the CCDCs should coordinate and expand and not duplicate existing services. Indeed, the Committee intends that the Secretary should take steps to ensure that needless duplication of services does not occur.

Potential CCDCs are required to have an advisory committee consisting of participants in the program, individuals with expertise in furnishing services the program offers, and representatives of the local community. Participants in this context refers to parents of infants and children. The Committee intends that parents will play the visible and vital role in the CCDCs that they do in the Head Start program itself. Some organizations may already have an advisory board in place that meets these criteria. In these cases, it is not necessary that a new advisory panel be established.

To help organizations design a CCDC, the Secretary is authorized to make planning grants to eligible agencies. This grant is intended to enable new or small organizations to develop a complete proposal for a CCDC. It is the intention of the Committee that these planning grants be awarded to economically disadvantaged agencies. Through this mechanism, the Committee intends that some organizations, such as those in rural areas, that may lack the size and stature to propose a comprehensive center will be encouraged to design one. Planning grants are limited to $35,000 and no more than 30 planning grants may be awarded. The end-product of a planning grant for any recipient agency should be a comprehensive operating grant proposal to be submitted to the Secretary.

Both the planning operating grants require a 20 percent non-federal match by the recipient organization. The non-federal contribution may be in cash or in-kind fairly evaluated. The non-federal share is designed to provide evidence of local interest and commitment to the undertaking. In making operating grants, the Committee intends that the Secretary will consider the likely ability of the sponsoring organization to provide the required non-federal share for the full five year authorization period. Such an indication will provide evidence of long-term local commitment.

The Committee is very interested in evaluating the results of these initiatives and has included requirements for a comprehensive evaluation by the Secretary. The Committee encourages the Secretary to take great care in designating the evaluation and to work closely with the CCDCs to ensure that the best possible analysis is done. The Secretary may require each local project to submit reports as necessary. The Committee intends that the Secretary will require each CCDC to commission an annual third-party evaluation of its operation and impact on the beneficiaries.

This section of the Head Start Act is authorized for five years, from fiscal year 1988 to 1993. The authorization for the Head Start program itself expires on September 30, 1990. It is the Committee's intention that this section of the Head Start law be carefully reviewed as part of the Head Start reauthorization and that it be reauthorized concurrently with the basic Head Start program in the future.

III. Major Provisions of the Legislation

Section 1: Title.

Section 2: Purpose—to provide financial assistance to projects on a multi-year basis designed to encourage intensive and comprehensive supportive services for infants and young children from low-income families which will enhance their physical, social, emotional and intellectual development and provide support to their parents and other family members.

Section 3: Adds a new section to the Head Start Act (Sec. 658).

Sec. 658(a): Secretary will enter into contracts with at least 10 but not more than 25 eligible agencies.

Sec. 658(a)(3): Factors to be considered by the Secretary in makeing awards.

Sec. 658(b): Authorizes planning grants to help agencies design comprehensive child development centers. Outlines information to be included in the application.

Sec. 658(c): Authorizes operating grants to eligible agencies to pay the federal share of carrying out projects of intensive and comprehensive supportive services for low-income infants, young children, parents and other family members. Requires some awards in rural areas. Outlines requirements for agencies that wish to sponsor CCDC's. Lists services potential CCDC's must offer to children and their families. Requires an advisory committee for each project.

Sec. 658(d): Establishes matching requirements (20 percent required local match, in kind services or cash). Limits size of planning grants to $35,000.

Sec. 658(e): Evaluation by Secretary of Health and Human Services and by local projects.

Sec. 658(f): Submission of report to Congress.

Sec. 658(g): Authorizes $25 million a year for fiscal year 1988 to fiscal year 1993.

Sec. 658(h): Definitions.

IV. Votes in Committee

No amendments were offered to the bill in Committee and the Committee voted unanimously to report the bill favorably. No roll call votes were taken pertaining to this bill.

V. Cost Estimate

U.S. Congress,
Congressional Budget Office,
Washington, DC, July 29, 1987.

Hon. Edward M. Kennedy,
Chairman, Committee on Labor and Human Resources,
U.S. Senate, Washington, DC.

Dear Mr. Chairman: The Congressional Budget Office has prepared the attached cost estimate for the Comprehensive Child Development Centers Act of 1987, as ordered reported from the Senate Committee on Labor and Human Resources on July 22, 1987.

If you wish further details on this estimate, we will be pleased to provide them.

With best wishes,

Sincerely,

EDWARD M. GRAMLICH,
Acting Director.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

1. Bill number: S. 1542.

2. Bill title: Comprehesive Child Development Centers Act of 1987.

3. Bill status: As ordered reported from the Senate Labor and Human Resources Committee, July 22, 1987.

4. Bill purpose: The purpose of this bill is to establish and authorize through 1993 a new federal grant program to provide financial assistance for comprehensive child development centers and to authorize a study to evaluate those programs. These grants are subject to subsequent appropriations action.

5. Estimated cost to the Federal Government:

[By fiscal years, in millions of dollars]

	1988	1989	1990	1991	1992	1993
Authorization levels:						
Comprehensive child development centers	25.0	25.0	25.0	25.0	25.0	25.0
Evaluation					.5	.5
Total authorization level	25.0	25.0	25.0	25.0	25.5	25.5
Estimated total outlays	11.5	23.5	25.0	25.0	25.5	25.5

The costs of this bill fall in Function 500.

Basis of estimate: The authorization levels for the new comprehensive child development center grant program and the program evaluation are the levels specifically stated in the bill. The program evaluation is authorized for $1 million for 1992 and 1993. This estimate reflects the assumption that it is funded equally over the two years. The estimate assumes full appropriation of authorized levels at the beginning of the year. Estimated outlays reflect the spending pattern of similar Human Development Service programs.

6. Estimated cost to State and local government: Passage of this bill would not directly affect the budgets of state and local governments. These new grants, which require 20 percent of funds to come from nonfederal sources, would be made on a competitive grant basis to head start agencies, community-based organizations, or other public or private non-profit agencies specializing in delivering services to children. These matched funds could come from state and local governments.

7. Estimate comparison: None.

8. Previous CBO estimate: None.

9. Estimate prepared by: Deborah Kalcevic.

10. Estimate approved by: C.G. Nuckols (for James L. Blum, Assistant Director for Budget Analysis).

VI. Regulatory Impact Statement

While Senate rules require that a committee assess the regulatory, inflationary and paperwork impact posed by legislation upon which they issue a report, such a prediction is difficult in this case. The comprehensive child development centers authorized by this act will be established by application and thus the committee can make no exact estimate as to how many such centers will be established.

While exact estimates are impossible, certain assumptions may be made. The bill should have little or no inflationary impact. Its only potential effect on the economy would be a positive one since the bill is designed to prevent welfare dependency, and to promote self-sufficiency and educational achievement. Some oversight will be required for the new centers, however no extensive regulatory changes are likely. Finally, it is highly unlikely that this legislation will have a significant effect on the volume or flow of paperwork at the local, state or federal levels.

VII. Changes in Existing Law

In compliance with rule XXVI paragraph 12 of the Standing Rules of the Senate, the following provides a print of the statute or the part or section thereof to be amended or replaced (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

Omnibus Budget Reconciliation Act of 1981

[Public Law 97-35, August 13, 1981 (95 Stat. 357)]

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TITLE VI—HUMAN SERVICES PROGRAMS

Subtitle A—Authorizations Savings for Fiscal Years 1982, 1983, and 1984

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Subchapter B—Head Start Programs

SHORT TITLE

Sec. 635. This subchapter may be cited as the "Head Start Act".

(42 U.S.C. 9801 note) Enacted August 3, 1981, P.L. 97-35, 95 Stat. 499.

STATEMENT OF PURPOSE AND POLICY

Sec. 636. (a) In recognition of the role which Project Head Start has played in the effective delivery of comprehensive health, educational, nutritional, social, and other services to economically disadvantaged children and their families, it is the purpose of this subchapter to extend the authority for the appropriation of funds for such program.

(b) In carrying out the provisions of this subchapter, the Secretary of Health and Human Services shall continue the administra-

tive arrangement responsible for meeting the needs of migrant and Indian children and shall assure that appropriate funding is provided to meet such needs.

(42 U.S.C. 9831 note) Enacted August 13, 1981, P.L. 97-35, 95 Stat. 499.

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ADVANCE FUNDING

SEC. 657. For the purpose of affording adequate notice of funding available under this subchapter, appropriations for carrying out this subchapter are authorized to be included in an appropriation Act for the fiscal year preceding the fiscal year for which they are available for obligations.

(42 U.S.C. 9852) Enacted August 13, 1981, P.L. 97-35, 95 Stat. 508.

CHILD DEVELOPMENT PROJECTS

SEC. 658. (a)(1) The Secretary is authorized to make grants to eligible entities in rural and urban areas to pay the Federal share of the cost of projects designed to encourage intensive and comprehensive supportive services which will enhance the physical, social, emotional, and intellectual development of low-income children from birth to compulsory school age, including providing necessary support to their parents and other family members.

(2) The Secretary shall enter into contracts, agreements, or other arrangements with at least 10 but not more than 25 eligible agencies to carry out the provisions of this section.

(3) In carrying out the provisions of this section, the Secretary shall consider—

(A) the capacity of the eligible agency to administer the comprehensive program for which assistance is sought;

(B) the proximity of the agencies and facilities associated with the project to the infants, young children, parents, and other family members, to be served by the project, or the ability of the agency to provide offsite services;

(C) the ability of the eligible agency to coordinate its activities with State and local public agencies (such as agencies responsible for education, health and mental health services, social services, child care, nutrition, income assistance, and other relevant services), with appropriate nonprofit private organizations involved in the delivery of eligible support services, and with the appropriate local educational agency;

(D) the management and accounting skills of the eligible agency;

(E) the ability of the eligible agency to use the appropriate Federal, State, and local programs in carrying out the project; and

(F) the organization's involvement of project participants and community representatives in the planning and operation of the project.

(b)(1)(A) The Secretary may make planning grants to elegible agencies to pay the Federal share of the cost of planning for projects funded under this section.

(B)(i) No planning grant may be for a period longer than 1 year.

(ii) Not more than 30 planning grants may be made under this subsection.

(2) Each eligible agency desiring to receive a planning grant under this section shall submit an application to the Secretary at such time, in such manner, and containing or accompanied by such information as the Secretary may reasonably require. Each such application shall—

(A) describe the capacity of the eligible agency to provide or ensure the availability of the intensive and comprehensive supportive services pursuant to the purposes of this subsection;

(B) describe the eligible infants, young children, parents, and other family members to be served by the project, including the number to be served and information on the population and geographic location to be served;

(C) describe how the needs of such children will be met by the program;

(D) describe the intensive and comprehensive supportive services that program planners intend to address in the development of the plan;

(E) describe the manner in which the project will be operated toegether with the involvement of other community groups and public agencies;

(F) specify the agencies that the organization intends to contact and coordinate activities with during the planning phase;

(G) identify a planning phase advisory board which includes prospective project participants, representatives of the community in which the project will be located, and individuals with expertise in the services to be offered; and

(H) describe the capacity of the eligible agency to raise the non-Federal share of the costs of the program and such other information as the Secretary may reasonably require.

(c)(1)(A) The Secretary shall make grants to eligible agencies selected in accordance with this section to pay the Federal share of the cost of carrying out projects for intensive and comprehensive supportive services for low-income infants, young children, parents, and other family members.

(B) The Secretary shall ensure that there will be projects receiving grants under this section in rural areas.

(2)(A) Each eligible agency desiring to receive an operating grant under this section shall—

(i) have a planning grant applicatio" approved under subsection (b) on file with the Secretary or have experience in conducting projects similar to the projects authorized by this section; and

(ii) submit an application at such time in such manner and containing or accompanied by such information as the Secretary may reasonably require.

(B) Each such application shall—

(i) identify the population and geographic location to be served by the project;

(ii) provide assurances that services are closely related to the identifiable needs of the target population;

(iii) provide assurances that each project will provide directly or arrange for—

(I) services for infants and young children designed to enhance the physical, social, emotional, and intellectual development of such infants and children and which include, but are not limited to, infant and child health services, including screening and referral; child care; early childhood development programs; early intervention services for children with, or at-risk of development delays, and nutritional services; and

(II) services for parents and other family members designed to better enable parents and other family members to contribute to their child's healthy development and that include, but are not limited to, prenatal care; education in infant and child development, health, nutrition, and parenting; and referral for education, employment counseling and training; assistance in securing adequate income support, health care, nutritional assistance, and housing;

(iv) identify the referral providers, agencies, and organizations that the program will use;

(v) provide assurances that the eligible intensive and comprehensive supportive services will be furnished to parents beginning with prenatal care and will be furnished on a continuous basis to the infants and young children so eligible, as well as to their parents and other family members;

(vi) describe how services will be furnished at offsite locations, if appropriate;

(vii) describe the extent to which the eligible agency, through its project, will coordinate and expand existing services as well as provide services not available in the area to be served by the project;

(vii) describe how the project will relate to the local educational agency as well as State and local agencies providing health, nutritional, education, social, and income maintenance services;

(ix) provide assurances that the eligible agency will pay the non-Federal share of the cost of the application for which assistance is sought from non-Federal sources;

(x) collect and provide data on groups of individuals and geographic areas served, including types of services to be furnished, estimated cost of providing comprehensive services on an average per user basis, types and nature of conditions and needs identified and treated, and such other information as the Secretary requires;

(xi) provide for an advisory committee consisting of—

(I) participants in the program,

(II) individuals with expertise in furnishing services the program offers and in other aspects of child health and child development, and

(III) representatives of the community in which the program will be located;

(xii) describe plans for evaluating the impact of the project; and

(xiii) include such additional assurances, including submitting necessary reports, as the Secretary may reasonably require.

(d)(1)(A) The Secretary shall pay to eligible agencies having applications approved under subsections (b) and (c) the Federal share of the cost of the activities described in the application.

(B) The Federal share shall be 80 percent for each fiscal year.

(C) The non-Federal share of payments under this section may be in cash or in kind fairly evaluated, including equipment or services.

(D) Payments under this section may be made in installments, and in advance or by way of reimbursement, with necessary adjustments on account of overpayments or underpayments, as the Secretary may determine.

No planning grant to a single eligible agency may exceed $35,000.

(e)(1) The Secretary shall, based on the projects assisted under this section, conduct or provide for, an evaluation of the success of projects authorized by this section.

(2) Each eligible agency receiving a grant under this section shall furnish information requested by evaluators in order to carry out this section.

(f) The Secretary shall prepare and submit to the Congress a report on the evaluation required by this subsection not later than October 1, 1992, together with such recommendations, including recommendations for legislation, as the Secretary deems appropriate.

(g)(1) There are authorized to be appropriated $25,000,000 for fiscal year 1988 and for each fiscal year ending prior to October 1, 1993, to carry out the provisions of this section (other than subsection (f)).

(2) There are authorized to be appropriated $1,000,000 for the period beginning October 1, 1991, and ending September 30, 1993, to carry out the provisions of subsecton (f).

(3) Funds appropriated pursuant to subsection (a) of this section shall remain available for obligation and expenditure for one fiscal year succeeding the fiscal year for which the funds were appropriated.

(h) As used in this section—

(1) the term "early intervention services" has the same meaning given that term by section 672(2) of the Education of the Handicapped Act;

(2) the term "eligible agency" means a Head Start agency, any community-based organization, and in addition includes an institution of higher education, a public hospital, a community development corporation, and any other public or private nonprofit agency or organization specializing in delivering social services to young children;

(3) the term "intensive and comprehensive supportive services" means—

(A) in the case of infants and young children, services designed to enhance the physical, social, emotional, and intellectual development of such infants and children and which includes, but is not limited to, infant and child health services, including screening and referral; child care; early childhood development programs; early intervention services for children with, or at-risk of developmental delays, and nutritional services; and

(B) in the case of parents and other family members, services designed to better enable parents and other family

members to contribute to their child's healthy development and which includes, but is not limited to, prenatal care; education in infant and child development, health, nutrition, and parenting; referral to education, employment counseling and training as appropriate; and assistance in securing adquate income support, health care, nutritional assisance, and housing;

(4) the term "low income" means persons who are from families having incomes below the poverty line as determined in accordance with section 673(2) of the Community Services Block Grant Act;

(5) the term "local educational agency" has the same meaning given that term by section 198(a)(7) of the Elementary and Secondary Education Act of 1965; and

(6) the term "institution of higher education" has the same meaning given that term by section 1201(a) of the Higher Education Act of 1965.

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